| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AEGX-126085759* | *State:* | *Arkansas* |
| *Filing Company:* | *Transamerica Life Insurance Company* | *State Tracking Number:* | *41961* |
| *Company Tracking Number:* | *GH AR0045807F01* | | |
| *TOI:* | *H03G Group Health - Accidental Death & Dismemberment* | *Sub-TOI:* | *H03G.000 Health - Accidental Death & Dismemberment* |
| *Product Name:* | *Accidental Death* | | |
| *Project Name/Number:* | *Accidental Death/GH AR0045807F01* | | |

## Filing at a Glance

Company: Transamerica Life Insurance Company

| | | |
|---|---|---|
| Product Name: Accidental Death | SERFF Tr Num: AEGX-126085759 | State: ArkansasLH |
| TOI: H03G Group Health - Accidental Death & Dismemberment | SERFF Status: Closed | State Tr Num: 41961 |
| Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment | Co Tr Num: GH AR0045807F01 | State Status: Approved-Closed |
| Filing Type: Form | Co Status: | Reviewer(s): Rosalind Minor |
| | Author: SPI ADMSLH | Disposition Date: 03/25/2009 |
| | Date Submitted: 03/23/2009 | Disposition Status: Approved-Closed |
| Implementation Date Requested: | | Implementation Date: |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: Accidental Death | Status of Filing in Domicile: Not Filed |
| Project Number: GH AR0045807F01 | Date Approved in Domicile: |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: Group |
| Submission Type: New Submission | Group Market Size: Small |
| Overall Rate Impact: | Group Market Type: Discretionary |
| Filing Status Changed: 03/25/2009 | Explanation for Other Group Market Type: |
| | State Status Changed: 03/25/2009 |
| Deemer Date: | Corresponding Filing Tracking Number: |

Filing Description:

Attached for your review and approval are the above referenced forms. These forms are new and do not replace any forms previously approved by your Department. The forms have been completed in "John Doe" fashion.

Group Certificate GC553 is a Group Accidental Death Certificate which provides accidental death benefits for owners of

small businesses and their employees. Coverage may include the following benefits and features: Dismemberment Benefit, Persistency Benefit, Full Premium, $1 first period, 30, 60 or 90 day right to examine. The certificates are offered on a guaranteed issue basis. Rates are subject to change after the first certificate year.

GM533 is the master policy under which GC533 certificate will be issued.

The Flesch Readability Score for Master Policy GM553 and GC553 certificate is 43.4 and 46.9, respectively. Microsoft Word 2003 was used to obtain these scores. Variable information is bracketed.

Enrollment Form GGA290 will be used to solicit this coverage.

This coverage may be marketed by direct response and telemarketing methods and possibly on the internet through our website.

We request approval of these forms in various dimensions, format and shading/colors. No dimension/format/shading/color change would produce unacceptable print. These products are guaranteed issue and will be mass marketed by direct response and telemarketing methods and possibly on the Internet through our website.

The referenced forms may be used in other media formats including translations into Spanish, Chinese, Korean, Vietnamese, Polish, etc. and in such case, we certify the content will not change.

## Company and Contact

**Filing Contact Information**


Mary DiMarcantonio, Filing Specialist
520 Park Avenue
Baltimore, MD 21201

mdimarcantonio@aegonusa.com
(410) 209-5263 [Phone]
(410) 209-5910[FAX]


**Filing Company Information**

| | | |
|---|---|---|
| Transamerica Life Insurance Company | CoCode: 86231 | State of Domicile: Iowa |
| 4333 Edgewood Road, N.E. | Group Code: 468 | Company Type: Life and Health |
| Cedar Rapids, IA 52499 | Group Name: | State ID Number: |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AEGX-126085759* | *State:* | *Arkansas* |
| *Filing Company:* | *Transamerica Life Insurance Company* | *State Tracking Number:* | *41961* |
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| *TOI:* | *H03G Group Health - Accidental Death & Dismemberment* | *Sub-TOI:* | *H03G.000 Health - Accidental Death & Dismemberment* |
| *Product Name:* | *Accidental Death* | | |
| *Project Name/Number:* | *Accidental Death/GH AR0045807F01* | | |

(410) 685-5500 ext. [Phone]

FEIN Number: 39-0989781

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| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AEGX-126085759* | *State:* | *Arkansas* |
| *Filing Company:* | *Transamerica Life Insurance Company* | *State Tracking Number:* | *41961* |
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| *Product Name:* | *Accidental Death* | | |
| *Project Name/Number:* | *Accidental Death/GH AR0045807F01* | | |

# Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $50.00 |
| Retaliatory? | Yes |
| Fee Explanation: | |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| Transamerica Life Insurance Company | $50.00 | 03/23/2009 | 26621551 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AEGX-126085759* | *State:* | *Arkansas* |
| *Filing Company:* | *Transamerica Life Insurance Company* | *State Tracking Number:* | *41961* |
| *Company Tracking Number:* | *GH AR0045807F01* | | |
| *TOI:* | *H03G Group Health - Accidental Death & Dismemberment* | *Sub-TOI:* | *H03G.000 Health - Accidental Death & Dismemberment* |
| *Product Name:* | *Accidental Death* | | |
| *Project Name/Number:* | *Accidental Death/GH AR0045807F01* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Rosalind Minor | 03/25/2009 | 03/25/2009 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AEGX-126085759* | *State:* | *Arkansas* |
| *Filing Company:* | *Transamerica Life Insurance Company* | *State Tracking Number:* | *41961* |
| *Company Tracking Number:* | *GH AR0045807F01* | | |
| *TOI:* | *H03G Group Health - Accidental Death & Dismemberment* | *Sub-TOI:* | *H03G.000 Health - Accidental Death & Dismemberment* |
| *Product Name:* | *Accidental Death* | | |
| *Project Name/Number:* | *Accidental Death/GH AR0045807F01* | | |

# Disposition

Disposition Date: 03/25/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AEGX-126085759* | *State:* | *Arkansas* |
| *Filing Company:* | *Transamerica Life Insurance Company* | *State Tracking Number:* | *41961* |
| *Company Tracking Number:* | *GH AR0045807F01* | | |
| *TOI:* | *H03G Group Health - Accidental Death & Dismemberment* | *Sub-TOI:* | *H03G.000 Health - Accidental Death & Dismemberment* |
| *Product Name:* | *Accidental Death* | | |
| *Project Name/Number:* | *Accidental Death/GH AR0045807F01* | | |

| Item Type | Item Name | Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Application | Approved-Closed | Yes |
| **Supporting Document** | Flesch Certification | Approved-Closed | Yes |
| **Supporting Document** | AR - NAIC TRANSMITTAL DOC | Approved-Closed | Yes |
| **Supporting Document** | AR - NAIC FORM FILING ATTACHMENT | Approved-Closed | Yes |
| **Supporting Document** | Explanation of Variability | Approved-Closed | Yes |
| **Supporting Document** | Cover Letter | Approved-Closed | Yes |
| **Form** | GROUP ACCIDENT INSURANCE POLICY | Approved-Closed | Yes |
| **Form** | Group Accident Insurance Certificate | Approved-Closed | Yes |
| **Form** | Enrollment Form | Approved-Closed | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AEGX-126085759* | *State:* | *Arkansas* |
| *Filing Company:* | *Transamerica Life Insurance Company* | *State Tracking Number:* | *41961* |
| *Company Tracking Number:* | *GH AR0045807F01* | | |
| *TOI:* | *H03G Group Health - Accidental Death & Dismemberment* | *Sub-TOI:* | *H03G.000 Health - Accidental Death & Dismemberment* |
| *Product Name:* | *Accidental Death* | | |
| *Project Name/Number:* | *Accidental Death/GH AR0045807F01* | | |

# Form Schedule

**Lead Form Number:** GM553

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved-Closed | GM553 | Policy/Contract/Fraternal Certificate | GROUP ACCIDENT INSURANCE POLICY | Initial | | 43 | GM553.PDF |
| Approved-Closed | GC553 | Certificate | Group Accident Insurance Certificate | Initial | | 47 | GC553.PDF |
| Approved-Closed | GGA290 | Application/Enrollment Form | Enrollment Form | Initial | | 40 | GGA290.PDF |

# TRANSAMERICA LIFE INSURANCE COMPANY

**A STOCK COMPANY**
**Home Office:** Cedar Rapids, Iowa
**Administrative Office:** [2700 West Plano Parkway
Plano, Texas 75075]

**Transamerica Life Insurance Company**
(Herein called the Company)

Having issued this Policy to

**[DISCOVER BANK]**
(Herein called Policyholder)

Agrees to pay the benefits herein provided with respect to persons Insured hereunder, subject to all terms of this Policy.

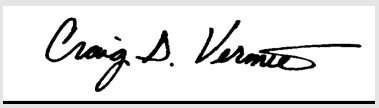
This Policy is issued in consideration of the payment of premium and statements made in the application herein provided, and shall take effect on [JANUARY 1, 2009] which shall be its date of issue. Policy anniversaries shall be [YEARLY] and each subsequent [YEAR]. This is a legal contract between Transamerica Life Insurance Company and the Policyholder.

This Policy is issued in the State of Missouri, and its terms shall be construed in accordance with the laws of the State of Missouri.

**RIGHT TO EXAMINE CERTIFICATE**

A person who enrolls for coverage may return the Certificate of Insurance within [30/60/90] days after its receipt to the Company at its Administrative Office. If the Certificate is returned, insurance under this Policy shall be deemed void from the Certificate's Effective Date. Any premium paid by the Insured will be refunded.

The provisions and conditions of this Policy shall form a part of the contract as fully as if recorded in detail above the signatures hereunder affixed.



Secretary

President

**Policy No.: [25467 GC553]**

**GROUP ACCIDENT INSURANCE POLICY**
**PROVIDING ACCIDENTAL DEATH [AND DISMEMBERMENT] BENEFITS**
**[RENEWABLE AT THE OPTION OF THE COMPANY]**

## DEFINITIONS

**INSURED** means the person named on the Certificate Schedule of Insurance. as an Insured, and whose coverage has become effective. The Insured must be the Owner or the Owner's employee age [18 through age 84].

**INJURY** means bodily harm caused by an accident which occurs while the Insured's Certificate is in force. The Injury must be the direct cause of Loss, independent of all other causes. Injury must not be caused by or contributed to by disease or bodily infirmity.

**INJURED** means having suffered an Injury.

**LOSS** means:
1. loss of life;
2. [with reference to hand or foot, complete severance at or above the wrist or ankle joint;
3. with reference to eye, the total and irrecoverable loss of the entire sight including best corrected vision of 20/200 or more.

Loss does not mean loss of use].

**PAYOR** is designated as such in the Certificate Schedule of Insurance and is responsible for paying premiums for the coverage under the Certificate.

**OWNER** means the entity partnership or proprietorship. Unless indicated differently in the Certificate Schedule of Insurance, the Owner is also the Payor. For purposes of exercising rights of ownership of the Certificate on behalf of the business, the Owner shall be the Authorized Person.

AUTHORIZED PERSON means the person authorized to sign the enrollment form on behalf of the business for purposes of exercising Owner rights in the Certificate. The Authorized Person is named on the Certificate Schedule of Insurance.

**[PARTICIPATING GROUP** means a group that requests to participate in the Insurance Trust known as the Policyholder and whose participation has been approved by the Company. The name of such group is shown in the Certificate Schedule of Insurance.]

## ELIGIBILITY

Each natural person [AGE 18 OR OLDER WHO IS A CREDIT CARDMEMBER (or who is the spouse of a CREDIT CARDMEMBER age 18 OR OLDER) OF DISCOVER BANK., WITH AN ACCOUNT IN GOOD STANDING], is eligible to become [an Owner] if that person resides in a state in which the insurance coverage may legally be offered.

Each natural person [AGE 18 THROUGH 84 WHO IS THE OWNER OR AN EMPLOYEE OF THE OWNER] is eligible to become an Insured. Such persons are herein called eligible persons.

No person shall be covered under more than one Certificate of Insurance under this Policy. Each Certificate may cover only one Insured. If a person is recorded by the Company as an Insured under more than one Certificate, such person shall be deemed to be Insured only under the Certificate which affords that person the greatest amount of coverage. Upon discovery of the duplication of coverage, any premium for the duplicate coverage made by, or on behalf of, the Insured will be refunded.

In no event will a corporation, partnership, or business entity, other than a natural person, be eligible to be covered.

**WHEN A PERSON BECOMES INSURED**

Each Owner will be issued a Certificate of Insurance which will indicate the coverage and the effective date of coverage.

Each eligible person shall become insured on the Effective Date shown in the Certificate Schedule of Insurance provided the Company receives the initial premium [within 21 days] of the Certificate Effective Date and while the Insured is alive.

**WHEN A PERSON'S INSURANCE ENDS**

Insurance ends on the earlier of:
1. the last day of the period covered by the last premium contribution; or
2. the first renewal date of the Certificate following the date this Policy is terminated or cancelled; or
3. the date the Insured is no longer an employee; or
4. [the first renewal date of the Certificate following the Insured's [85th]birthday].`

The Owner may cancel this coverage upon notice to the Company. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made.

In the event this Policy terminates, the Company will give the Owner 31 days notice of this event.

In the event the insurance terminates, it does not affect payment for a Loss which began while the coverage was in force.

**AMOUNTS OF INSURANCE - SCHEDULE OF INSURANCE**

When an eligible person enrolls as an Insured or Owner under this Policy, he or she will receive coverage as described in the Coverage section of this Policy. The amounts of insurance for each Insured shall be the amount shown in the Certificate Schedule of Insurance issued for each individual Insured.

**COVERAGE / COVERED LOSSES**

**ACCIDENTAL DEATH [AND DISMEMBERMENT]**

If the Insured suffers a Loss as a direct result of an Injury from an accident not otherwise excluded in this Policy and the Loss occurs within [90] days following the date of the accident which caused the Injury, the Company will pay the applicable benefit amount specified on the Certificate Schedule of Insurance for the Loss.

**[SCHEDULE OF BENEFITS**

**ACCIDENTAL DEATH AND DISMEMBERMENT**

If, as a result of an Injury, the Insured suffers any of the following Losses within [90] days after the date of an accident which caused such Injury, the Company will pay the benefit shown below:

| SCHEDULE OF LOSSES AND BENEFITS | |
|---|---|
| **LOSS** | **BENEFIT** |
| LIFE | THE PRINCIPAL SUM |
| Both Hands or Both Feet or Sight of Both Eyes | The Principal Sum |
| One Hand and One Foot | The Principal Sum |
| One Hand and Sight of One Eye | The Principal Sum |
| One Foot and Sight of One Eye | The Principal Sum |
| One Hand or One Foot or Sight of One Eye | One-Half the Principal Sum |

Principal Sums are as specified in the Certificate Schedule of Insurance. Only one of the above benefits, the largest, will be paid for multiple Losses that result from one accident.]

**EXPOSURE AND DISAPPEARANCE**

If by reason of an Injury covered by this Policy the Insured is unavoidably exposed to the elements and, as a result of such exposure, suffers a Loss for which a benefit is otherwise payable, the Loss will be covered under the terms of this Policy.

If the Insured is involved in an accident which results in the collision, crash or sinking of a licensed public conveyance in which he was a passenger and his body is not located within one year of such accident, it will be presumed that the Insured died as a result of an Injury.

[PERSISTENCY BENEFIT

The Company will pay the Persistency Benefit stated in the Certificate Schedule of Insurance each year for five years beginning with the first Certificate anniversary date as long as this Policy and the Certificate remain in force.]

**EXCLUSIONS**

No benefit shall be paid for Loss or Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (in Colorado and Missouri, while sane);
2. any active participation in a riot, insurrection or war, either declared or undeclared;
3. the Insured's taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. the Insured's blood alcohol level being .08 percent weight by volume or higher;
5. the Insured's operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. the Insured committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. sickness, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
9. taking alcohol in combination with any drug, medication or sedative; or
10. military or combat activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority.

**RENEWAL CONDITIONS**

Continuation of an Insured's Certificate is contingent upon continuation of this Policy. This Policy may be cancelled by the Company by providing written notice to the [Participating Group/Policyholder] at least [60] days prior to cancellation of this Policy.

The Company has the right to change the table of rates from time to time. There will be no change in the rate for the Insured due to any physical impairment or claim incurred. All premiums will be based on the Company's table of rates for this Policy on the date of the renewal.

Renewal premiums are due on the first day of each renewal period. The Certificate will expire if the premium is not paid by the end of the Grace Period.

**[REDUCTION**

The Accidental Death [and Dismemberment] benefit will reduce by one-half (50%) of that otherwise payable if the Insured attains age 70 before the date of Injury resulting in a covered Loss.]

## PREMIUM

[For the first (2)(3) month(s) of coverage, the premium of $1.00 will be paid by the Participating Group/Policyholder.] Premiums for Insureds are included on the attached rate sheet.

## BENEFICIARY

The Owner chooses the primary beneficiary who receives the benefit when the Insured dies.

If the beneficiary is a corporation or partnership and is dissolved, the right to receive benefits shall pass to any individual or entity designated in writing to the Company that is signed by at least seventy percent (70%) of the former partners or directors of the beneficiary as the case may be.

At the option of the Owner, the Insured may designate a portion of the benefit [not to exceed [fifty per cent (50%)] of the Benefit Amount stated in the Certificate Schedule of Insurance. Unless the Insured specifies otherwise, such designated portion of the benefits are to be paid as follows:

1. at the Insured's death, it will be paid to the Insured's living lawful spouse; or if there is not one,
2. in equal shares to the Insured's living lawful children; or if there are none,
3. in equal shares to the Insured's living lawful parents; or if there are none,
4. in equal shares to the Insured's living lawful brothers and sisters; or if there are none,
5. to the Insured's estate.

Spouse means only the one to whom the Insured is lawfully married on the date of the Insured's death. Except in the case of a legal adoption, lawful children, parents, brothers and sisters do not mean "step" children, parents, brothers or sisters.

### CHANGE OF OWNER

The Owner has the right to transfer the Certificate to a new Owner by notifying the Company. Request for such change must be in writing while the Insured is living. The change must then be approved by the Company in writing. The change is effective as of the date it was signed by the Company. The Company is not liable for action taken by the Company before the request is acknowledged. If the Authorized Person is terminated and there is not a person to act as Owner, a new Owner may be designated upon submission to the Company of satisfactory proof that the person designated is authorized to act as an Owner.

## GENERAL PROVISIONS

### ENTIRE CONTRACT

This Policy is issued in consideration of the application and payment of the premium. The Policy, and any attached papers form the entire contract of insurance.

Any change in this Policy must be in the form of an amendment or endorsement signed by one of the officers of the Company. Agreements made by the Policyholder and the Company in this manner will be binding on all persons insured. Certificate anniversaries are measured from the Certificate Effective Date.

### INCONTESTABILITY

We cannot contest the Certificate except for fraud or for not paying premiums.

### INFORMATION TO BE FURNISHED

The Policyholder shall furnish the Company with any information required to administer this Policy. The Company shall have the right to inspect any record of the Policyholder or in possession of the Policyholder which relates to this Policy.

**CLERICAL ERROR**

A clerical error in the records relative to this insurance shall not invalidate insurance or cause insurance to be in force or to continue in force. Upon discovery of such error, an equitable adjustment shall be made in the premium.

**INSURED'S CERTIFICATE**

The Company will issue an individual Certificate to each Insured. The Certificate will describe the insurance coverage and state to whom the benefits will be paid.

**CHANGE OF BENEFICIARY**

Unless the Owner has named an irrevocable beneficiary, the Owner may change the beneficiary at any time by writing to the Company at its Administrative Office. An irrevocable beneficiary is one that can never be changed unless the beneficiary approves the change. Once the Company records the change, it will take effect as of the day the Owner signed the request, subject to any claim payment made before such recording.

**CHANGE OF OWNER**

The Owner has the right to transfer the Certificate to a new Owner by notifying the Company. Request for such change must be in writing while the Insured is living. The change must then be approved by the Company in writing. The change is effective as of the date it was signed by the Company. The Company is not liable for action taken by the Company before the request is acknowledged.

**PAYMENT OF PREMIUM**

All premiums due by the terms of this Policy shall be paid by the [Participating Group/Policyholder] to the Administrative Office of the Company on or prior to the day they are due.

[For the first 30/60/90 days of coverage, the premium will be paid by the [Participating Group/Policyholder].

Owners are required to contribute 100 percent of the premium payable under this Policy for each Certificate [after the first (2)(3) month(s)]. If at any time the [Participating Group/Policyholder] refuses to accept such contributions and pay the premium for the Owner, the Owner may pay such premium directly to the Administrative Office of the Company on or prior to the day it is due.

[If no initial premium is requested by the Company with the enrollment form, the Owner shall have 21 days from the Effective Date shown on the Certificate Schedule of Insurance to pay the first premium. If the first premium is not paid within such 21 day period, the Certificate shall be considered void from the beginning and no benefit will be paid for any Loss.]

**GRACE PERIOD**

If a premium is not paid when due, the insurance shall be in default. The Company will allow a 31-day grace period to pay each premium after the first one. If a premium is not paid on or before the end of the grace period, the insurance shall terminate, effective the last day of the period covered by the last premium contribution. No benefits are paid for a Loss occurring after the expiration of the Grace Period.

**REINSTATEMENT**

The Insured's Certificate will lapse if the Insured does not pay his or her premium before the end of the Grace Period. If the Company later accepts a premium and does not require an application for reinstatement, that payment will put the Certificate back in force. If the Company requires an application for reinstatement, the Certificate will be put back in force when the Company approves it, and the required premium is received. If the Company does not approve it, the Certificate will be put back in force on the 45$^{th}$ day after the date of application for reinstatement, unless the Company gives the Insured prior written notice of its disapproval.

The reinstated Certificate only covers Loss due to an Injury that occurs after the date of reinstatement. In all other respects, the Company and the Insured have the same rights under the Certificate as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement.

**NOTICE OF CLAIM**

Written notice of claim must be given to the Company within 30 days after a covered Loss occurs. If it is not reasonably possible to furnish notice, within that time, it must be given as soon as possible. The notice should include the Insured's name and Certificate number as shown in the Certificate Schedule of Insurance. Notice should be mailed to the Company at its administrative office.

**CLAIM FORMS**

When the Company receives the Notice of Claim, the Company will send the claimant forms for filing Proof of Loss. If the Company does not send the forms within 15 days, the claimant is deemed to have complied with the requirements for providing Proof of Loss if written Proof of Loss covering the occurrence, character, and extent of the Loss is provided to us within the time fixed for Proof of Loss.

**PROOF OF LOSS**

Written proof of loss must be given to the Company within 90 days after the date of the Loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

**MISSTATEMENT OF AGE**

If the age of an Insured has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, the Company accepts a premium for any period when coverage would not normally have been in effect, then the Company's liability for such period shall be a refund, upon request, of all premiums paid for such period.

**TIME OF PAYMENT OF CLAIMS**

The Company will pay all benefits covered by this Policy as soon as the Company receives proper written Proof of Loss sufficient to determine liability.

**PAYMENT OF CLAIMS**

All benefits are payable to the Insured, if living. Loss of life benefits for the Insured are payable in accordance with the beneficiary designation in effect at the time of payment. Other benefits will be paid to the Insured. Any other benefits, other than for Loss of life, unpaid at the Insured's death may be paid, at the Company's option, either to the Insured's beneficiary or estate.

**AUTOPSY [AND PHYSICAL EXAM]**

The Company, at its own expense, may have an autopsy done where it is not forbidden by law. [The Company shall also have the right to examine the Insured when and as often as necessary while a claim is pending].

**LEGAL ACTIONS**

No action can be brought to recover on this Policy for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required.

If a time limit of this Policy is less than allowed by the laws of the state where the Owner lives, the limit is extended to meet the minimum time allowed by such law.

**[DUPLICATION OF COVERAGE**

The Certificate supersedes any Certificate previously issued for the Insured under Policy Number [25517 GC553]. The Insured may qualify under one Certificate only. If the Insured is covered under more than one Certificate, the Company will consider that person to be insured under the Certificate which provides the greatest amount of coverage. Upon discovery of the duplication, the Company will refund any duplicated payments which may have been made on behalf of that person.]

**OTHER INSURANCE**

If the Insured is covered under more than one Accidental Death [and Dismemberment] Policy or Certificate in effect with the Company or any AEGON affiliate at any one time, the Company's maximum liability is limited to the lesser of the total amount of benefits payable under all such policies and certificates or [$1,000,000.] Upon discovery of duplication in excess of the Company's maximum liability, the Company will refund all premiums paid for all such Policies or Certificates. The excess will be voided and all premiums paid for such excess shall be returned.

# TRANSAMERICA LIFE INSURANCE COMPANY

**A Stock Company**
**Home Office**: Cedar Rapids, Iowa
**Administrative Office**: [2700 West Plano Parkway, Plano, Texas 75075]

## CERTIFICATE OF INSURANCE

The person insured and benefits are shown in the Schedule of Insurance.

**Transamerica Life Insurance Company** (herein called "we," "us" or "our") has issued Policy No.[25467 GC553] to [DISCOVER BANK] (herein called Policyholder) which makes available accidental death [and dismemberment] insurance for eligible persons.

We agree to pay the benefits herein provided with respect to the person insured hereunder, subject to all terms of the Policy.

**RIGHT TO EXAMINE CERTIFICATE**

If you, the Owner, are not satisfied with this insurance, you may void it by returning this Certificate within [30/60/90] days after you receive it to our Administrative Office. You will receive a full refund of any premium you have paid.

The records maintained by the [Participating Group/Policyholder] shall determine the insurance provided under the Policy for the Insured. Important provisions of the Policy are outlined herein.

Craig D. Vermeer
Secretary

Brenda Clancy
President

**INSURED:**

[JOHN DOE
221 ANYSTREET
APARTMENT #1231
ANYTOWN, USA 12345]

**CERTIFICATE NUMBER:**

[82A1000000]

**GROUP ACCIDENT INSURANCE**
**PROVIDING ACCIDENTAL DEATH [AND DISMEMBERMENT] BENEFITS**
[RENEWABLE AT THE OPTION OF THE COMPANY]

# TRANSAMERICA LIFE INSURANCE COMPANY

## SCHEDULE OF INSURANCE

This Schedule of Insurance is part of the Certificate. It supersedes any Schedule of Insurance bearing an earlier Effective Date issued under Policy No. [25467 GC553] to [DISCOVER BANK]

**[PARTICIPATING GROUP NUMBER: XXXXX]**

**[PARTICIPATING GROUP: XXXXXXXXX]**

**CERTIFICATE NUMBER**: [8200000000]

**EFFECTIVE DATE**: [01-01-2009]

**INSURED**: [JOHN KEYMAN

221 ANYSTREET
APARTMENT 1231
ANYTOWN, USA 12345]

**OWNER**: ABC COMPANY
**AUTHORIZED PERSON :**
**PAYOR**: ABC COMPANY

**MONTHLY PREMIUM**: [$12. 50]

**PREMIUM CONTRIBUTION**: [100% AFTER THE FIRST 30/60/90 DAYS]

### SCHEDULE OF INSURANCE

| **PRINCIPAL SUMS**: | **BENEFIT AMOUNT** |
|---|---|
| **ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT THROUGH INSURED'S AGE 69** | **[$100,000.00]** |
| **PERSISTENCY BENEFIT (PAYABLE ON CERTIFICATE ANNIVERSARY EACH YEAR FOR 5 CONSECUTIVE YEARS)** | **[$ 25.00]** |

**INSURED'S AGE 70 AND OVER:**

**THE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT IS [ONE-HALF (50%)] OF THE ABOVE AMOUNT IF THE INSURED HAS ATTAINED AGE 70., BEFORE THE DATE OF INJURY RESULTING IN A COVERED LOSS.**

**ONLY ONE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT, THE LARGEST, WILL BE PAID FOR MULTIPLE LOSSES THAT RESULT FROM ONE ACCIDENT.**

**[COVERAGE TERMINATES AT THE INSURED'S AGE 85.]**

## DEFINITIONS

**INSURED** means the person named on the Schedule of Insurance, provided coverage has become effective. The Insured must be you or your employee age [18 through age 84].

**INJURY** means bodily harm caused by an accident which occurs while this Certificate is in force. The Injury must be the direct cause of Loss, independent of all other causes. Injury must not be caused by or contributed to by disease or bodily infirmity.

**INJURED** means having suffered an Injury.

**LOSS** means:
1. loss of life;
2. [with reference to hand or foot, complete severance at or above the wrist or ankle joint;
3. with reference to eye, the total and irrecoverable loss of the entire sight including best-corrected vision of 20/200 or more.

Loss does not mean loss of use.]

**PAYOR** is designated as such in the Schedule of Insurance and is responsible for paying premiums for the coverage under this Certificate.

**OWNER** (herein called "you," "your," or "yours") means you the entity, partnership or proprietorship. Unless indicated differently in the Schedule of Insurance, the Owner is also the Payor. For purposes of exercising rights of ownership of this Certificate on behalf of the business, the Owner shall be the Authorized Person.

**AUTHORIZED PERSON** means the person authorized to sign the enrollment form on behalf of the business for purposes of exercising Owner rights in this Certificate. The Authorized Person is named on the Schedule of Insurance.

## WHEN INSURANCE BEGINS

Issuance of a Certificate is not a waiver of any of the following conditions:

An eligible Insured will become insured under this Certificate at 12:01 a.m., Standard Time on the Certificate Effective Date following acceptance by us of the enrollment form, if required, and upon receipt of the first premium [before][within 21 days] of the Certificate Effective Date. The premium and the Effective Date of Coverage are shown on the Certificate Schedule of Insurance.

## WHEN INSURANCE ENDS

Insurance ends on the earlier of:
1. the last day of the period covered by the last premium contribution; or
2. the first renewal date of this Certificate following the date the Policy is terminated or cancelled; or
3. the date the Insured is no longer an employee; or
4. [the first renewal date of this Certificate following the Insured's 85th birthday.]`

You may cancel this coverage upon notice to us. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made.

In the event the Policy terminates, we will give you 31 days notice of this event.
In the event the insurance terminates, it does not affect payment for a Loss which began while the coverage was in force.

## COVERAGE

### ACCIDENTAL DEATH [AND DISMEMBERMENT]

If the Insured suffers a Loss as a direct result of an Injury from an accident not otherwise excluded in the Policy and the Loss occurs within [90] days following the date of the accident which caused the Injury, we will pay the applicable benefit amount specified on the Certificate Schedule of Insurance for the Loss.

### [SCHEDULE OF BENEFITS ACCIDENTAL DEATH AND DISMEMBERMENT

If, as a result of an Injury, the Insured suffers any of the following Losses within [90] days after the date of an accident which caused such Injury, we will pay the benefit shown below:

SCHEDULE OF LOSSES AND BENEFITS

| | |
|---|---|
| Life | THE PRINCIPAL SUM |
| Both Hands or Both Feet or Sight of Both Eyes | The Principal Sum |
| One Hand and One Foot | The Principal Sum |
| One Hand and Sight of One Eye | The Principal Sum |
| One Foot and Sight of One Eye | The Principal Sum |
| One Hand or One Foot or Sight of One Eye | One-Half the Principal Sum |

Principal Sums are as specified on the Schedule of Insurance. Only one of the above benefits, the largest, will be paid for multiple Losses that result from one accident.]

### EXPOSURE AND DISAPPEARANCE

If by reason of an Injury covered by the Policy the Insured is unavoidably exposed to the elements and, as a result of such exposure, suffers a Loss for which a benefit is otherwise payable, the Loss will be covered under the terms of the Policy.

If the Insured is involved in an accident which results in the collision, crash or sinking of a licensed public conveyance in which he was a passenger and his body is not located within one year of such accident, it will be presumed that the Insured died as a result of an Injury.

[PERSISTENCY BENEFIT

We will pay the Persistency Benefit stated in the Schedule of Insurance each year for five years beginning with the first Certificate anniversary date as long as the Policy and Certificate remain in force.]

## EXCLUSIONS

No benefit shall be paid for Loss or Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (in Colorado and Missouri, while sane);
2. any active participation in a riot, insurrection or war, either declared or undeclared;
3. the Insured's taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. the Insured's blood alcohol level being .08 percent weight by volume or higher;
5. the Insured's operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. the Insured committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. sickness, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
9. taking alcohol in combination with any drug, medication or sedative; or
10. military or combat activities while serving in the forces, National Guard or organized reserve corps in any state, country or international authority.

## RENEWAL CONDITIONS

Continuation of this coverage is contingent upon the continuation of the Policy.

Prior to the expiration of the Grace Period of this Certificate, the payment of the renewal premium is required to keep this Certificate in effect.

The Certificate may be renewed for further periods by the payment in advance or within the Grace Period of the renewal premium at the rate in effect at the time of renewal. There will be no change in the Insured's rate due to any physical impairment or claim incurred.

Renewal premiums are due on the first day of each renewal period. Coverage will terminate if the premium is not paid by the end of the Grace Period.

## [REDUCTION

The Accidental Death [and Dismemberment] benefit will reduce by one-half (50%) of that otherwise payable if the Insured attains age 70 before the date of Injury resulting in a covered Loss.]

## BENEFICIARY

You choose the primary beneficiary who receives the benefit when the Insured dies.

If the beneficiary is a corporation or partnership and is dissolved, the right to receive benefits shall pass to any individual or entity designated in writing to us that is signed by at least seventy percent (70%) of the former partners or directors of the beneficiary as the case may be.

At the option of the Owner, the Insured may designate a portion of the benefit not to exceed [fifty per cent (50%)] of the Benefit Amount stated in the Schedule of Insurance. Unless the Insured specifies otherwise, such designated portion of the benefits are to be paid as follows:

1. at the Insured's death, it will be paid to the Insured's living lawful spouse; or if there is not one,
2. in equal shares to the Insured's living lawful children; or if there are none,
3. in equal shares to the Insured's living lawful parents; or if there are none,
4. in equal shares to the Insured's living lawful brothers and sisters; or if there are none,
5. to the Insured's estate.

Spouse means only the one to whom the Insured is lawfully married on the date of the Insured's death. Except in the case of a legal adoption, lawful children, parents, brothers and sisters do not mean "step" children, parents, brothers or sisters.

## GENERAL PROVISIONS

### ENTIRE CONTRACT

This Certificate is furnished in accordance with and subject to the terms of the Policy. It is not part of the Policy, but it is evidence of the insurance provided under the Policy. The Policy and any attachments form the entire contract of insurance. No agent may change or waive any provisions of the Policy under which this coverage is provided.

### INCONTESTABILITY

We cannot contest this Certificate except for fraud or for not paying premiums.

### CHANGE OF BENEFICIARY

Unless you, the Owner, named an irrevocable beneficiary, you may change the beneficiary at any time by writing to us at our Administrative Office. An irrevocable beneficiary is one that can never be changed unless the beneficiary approves the change. Once we record the change, it will take effect as of the day you signed the request, subject to any claim payment made before such recording.

**CHANGE OF OWNER**

The Owner has the right to transfer this Certificate to a new Owner by notifying us. Request for such change must be in writing while the Insured is living. The change must then be approved by us in writing. The change is effective as of the date it was signed by us. We are not liable for action taken by us before the request is acknowledged. If the Authorized Person is terminated and there is not a person to act as Owner, a new Owner may be designated upon submission to us of satisfactory proof that the person designated is authorized to act as an Owner.

**PAYMENT OF PREMIUM**

All premiums due by the terms of the Policy shall be paid to our Administrative Office on or prior to the day they are due.

[For the first 30/60/90 days of coverage, the premium will be paid by the[Participating Group/Policyholder].

After the first 30/60/90 days, you are required to contribute 100 percent of the premium payable for this Certificate.]

We have the right to change the table of rates on any premium due date. We will provide written notice to the Policyholder at least 31 days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed.

**GRACE PERIOD**

If a premium is not paid when due, the insurance shall be in default. We will allow a 31-day grace period to pay each premium after the first one. If a premium is not paid on or before the end of the grace period, the insurance shall terminate, effective the last day of the period covered by your last premium contribution. No benefits are paid for a Loss occurring after the expiration of the Grace Period.

**REINSTATEMENT**

This Certificate will lapse if premiums are not paid before the end of the Grace Period. If we later accept a premium and do not require an application for reinstatement, that payment will put the Certificate back in force. If we require an application for reinstatement, this Certificate will be put back in force when we approve it and the required premium is received. If we do not approve it, the Certificate will be put back in force on the 45th day after the date of application for reinstatement, unless we give you prior written notice of its disapproval.

The reinstated Certificate only covers Loss due to an Injury that occurs after the date of reinstatement. In all other respects, you and we have the same rights under the Certificate as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement.

**NOTICE OF CLAIM**

Written notice of claim must be given to us within 30 days after a covered Loss occurs. If it is not reasonably possible to furnish notice within that time, it must be given as soon as possible. The notice should include the Insured's name and Certificate Number as shown on the Schedule of Insurance. Notice should be mailed to us at our Administrative Office.

**CLAIM FORMS**

When we receive the Notice of Claim, we will send the claimant forms for filing Proof of Loss. If we do not send the forms within 15 days, the claimant is deemed to have complied with the requirements for providing Proof of Loss if written Proof of Loss covering the occurrence, character, and extent of the Loss is provided to us within the time fixed for Proof of Loss.

**PROOF OF LOSS**

Written proof of loss must be given to us within 90 days after the date of the Loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

**TIME OF PAYMENT OF CLAIMS**

We will pay all benefits covered by the Policy as soon as we receive proper written Proof of Loss sufficient to determine liability.

**PAYMENT OF CLAIMS**

All benefits are payable to you subject to the beneficiary designation in effect at the time of payment.

**MISSTATEMENT OF AGE**

If the age of the Insured has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, we accept a premium for any period when coverage would not normally have been in effect, then our liability for such period shall be a refund, upon request, of all premiums paid for such period.

**AUTOPSY [AND PHYSICAL EXAM]**

At our expense, we may have an autopsy done where it is not forbidden by law. [We shall also have the right to examine the Insured when and as often as necessary while a claim is pending].

**LEGAL ACTIONS**

No action can be brought to recover on the Policy for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required.

If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

**DUPLICATION OF COVERAGE (SUPERSEDES)**

This Certificate supersedes any Certificate previously issued for the Insured under Policy Number [25517 GC553]. The Insured may qualify under one Certificate only. If the Insured is covered under more than one Certificate, we will consider that person to be insured under the Certificate which provides the greatest amount of coverage. Upon discovery of the duplication, we will refund any duplicated payments which may have been made on behalf of that person.

**OTHER INSURANCE**

If the Insured is covered under more than one Accidental Death [and Dismemberment] Policy or Certificate in effect with us or any AEGON affiliate at any one time, our maximum liability is limited to the lesser of the total amount of benefits payable under all such policies and certificates or [$1,000,000]. Upon discovery of duplication in excess of our maximum liability, we will refund all premiums paid for all such Policies or Certificates. The excess will be voided and all premiums paid for such excess shall be returned.

# [Accidental Death] [and Dismemberment] [Insurance] [ Key Man AD]
# [Variable Logo]
# [ABC Financial Institution]
# Enrollment Form

Underwritten by

## Transamerica Life Insurance Company

Home Office: Cedar Rapids, IA  Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075]

[Business Name]
[123 Main Street]
[Apartment #X]
[Columbia, SC XXXXX]

[Please respond by: [Month XX, XXXX]]

[Bar Code for Scanning Purposes] [123-103B] [5060002091717] [MZ2000104/0000F & 0001F]

## [HOW TO ENROLL FOR COVERAGE

Complete, sign and mail this form by [xx/xx/xxxx] to enroll for coverage.

If enrolling additional employees
1. make a copy of the enrollment form for each employee
2. complete all the information,
3. both an Authorized Person for the business and the employee sign and date the application for coverage.]

[AFTER the [One/Two/Three MONTHS] NO COST TO YOU PERIOD, COVERAGE CONTINUES AT THE RATES SHOWN BELOW.]

[Check [below] to select Insurance Coverage:]

| [Coverage Amount | Monthly Premium Per Insured |
|---|---|
| ☐ $ 100,000 | $ 12.50 |
| ☐ $ 200,000 | $ 25.00 |
| ☐ $ 300,000 | $ 37.50 |
| ☐ $ 400,000 | $ 50.00 |
| ☐ $ 500,000 | $ 62.50 |
| ☐ $ 750,000 | $ 93.75 |
| ☐ $1,000,000 | $125.00] |

[Maximum Coverage is [$1,000,000]]

**Business Information:**
Name of Business (if different than printed above:)_____
Address (if different than printed above):_____

Nature of Business: _____Number of Years in Business: _____

£ Partnership £ Sub Chapter S Corp £ Sole Proprietorship £ Corporation

[Home Phone _____] Tax ID No.: _____]
[Business Phone_____] [e-mail address _____]

**[Proposed Insured][Employee] Information:**
Name: _____Birthdate:_____M/F:_____E-Mail Address:_____
Street Address:_____City:_____State:_____Zip:_____Phone:(___)_____]

## [Irrevocable Beneficiary Designation

**(An irrevocable beneficiary is one that cannot be changed unless the beneficiary approves the change)**

[Please indicate the percentage of Benefits for each Beneficiary listed below next to the Beneficiary's name.] [Unless otherwise indicated, the beneficiary shall be the Business.] The employee to be insured may designate an irrevocable beneficiary. [*Business must be allocated, at minimum, 50% of the benefit amount.] [If you list benefit percentages, the total must equal 100%]*

**Primary Beneficiary(ies)**

| **Business** | **Other (No more than 50% if selected)** |
|---|---|
| Name of Business: | Full Name of Person: |
| Address: | Address: |
| Percentage: | Birth date: |
| | Relationship: |
| | Percentage:] |

## [Complete and sign][Please read and sign below:]

[I understand that in order to enroll for this coverage, I, the Payor, must be a Discover Bank accountholder or the spouse of a Discover Bank accountholder, age 18 through 80 with an account in good standing and reside in a state in which this insurance may legally be offered. The first 30 days of coverage will be provided at no cost to me and, as long as the policy is in force. I also understand that coverage reduces by fifty percent (50%) at the Insured's age 70. I have read the fraud notice [below][on the back of this enrollment form], as it applies to my state of residence.] [This Enrollment Form is part of the Certificate of Insurance to which it is attached.]

[SIGN, DATE AND MAIL] I, the Payor, hereby enroll the [named Employee][proposed Insured] in the [[Group] [Accidental Death] [and Dismemberment] [Insurance] [Plan] underwritten by Transamerica Life Insurance Company. I, the Payor, hereby consent to the release of my [ABC Bank] [checking] [credit card] account number to third parties for the purpose of billing and processing in connection with my request for [Accidental] [Death][and Dismemberment] Coverage.] [This authority is to remain in effect until I cancel it by written notification to the Company at least 30 days in advance of the intended termination date of my coverage.] Coverage begins on the Effective Date stated on the Certificate of Insurance [provided the first premium is paid]. I[*A [$0.50] administrative fee will be added for each automatic account billing.] I acknowledge that I have received, read and understand the insurance disclosures [on the reverse side of this form][and][below]. I acknowledge that Transamerica made no legal or tax representations about the deductibility of premium or the tax treatment to employees in the [Plan]. **The person executing below on behalf of an entity or partnership represents to Transamerica that such party is authorized to do so by requisite act of the board of directors or partners, as the case may be. The person signing as Owner below is considered the Owner on behalf of the Business (Authorized Person) for purposes of exercising Owner rights in the [Plan].**

**[By signing below, I certify that [I] [the] [Proposed Insured][Employee] [do] [does] not have Accidental Death and Dismemberment coverage with Monumental Life Insurance Company, Stonebridge Life Insurance Company, Transamerica Life Insurance Company or Transamerica Financial Life Insurance Company, and I know that liability is limited to a total of $1,000,000 in the above companies. Upon discovery of duplication in excess of our maximum liability we will refund all premiums paid for all such policies or certificates. The excess will be voided and all premiums paid for such excess shall be returned.]**

[Print full name of Owner (Authorized Person): _____]Title:[_____]

[Owner] _____] [Date _____/_____/_____
[Signature of [Owner of business or Authorized Person] (Required)
(Signer considered Authorized Person) ] Mo. Day Yr.]

[Employee] _____ [Date _____/_____/_____]
[Signature of [Proposed Insured] [Employee] (Required) Mo. Day Yr.]

[John Doe XXXXXXX]
Licensed Resident Agent

**[Residents of ARKANSAS, NEW MEXICO, and OHIO: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

**Residents of DISTRICT OF COLUMBIA:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Residents of FLORIDA:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Residents of KENTUCKY:** Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

**Residents of LOUISIANA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Residents of MAINE, TENNESSEE and WASHINGTON**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Residents of MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Residents of NEW JERSEY:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Residents of NEW YORK:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Residents of PENNSYLVANIA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AEGX-126085759* | *State:* | *Arkansas* |
| *Filing Company:* | *Transamerica Life Insurance Company* | *State Tracking Number:* | *41961* |
| *Company Tracking Number:* | *GH AR0045807F01* | | |
| *TOI:* | *H03G Group Health - Accidental Death & Dismemberment* | *Sub-TOI:* | *H03G.000 Health - Accidental Death & Dismemberment* |
| *Product Name:* | *Accidental Death* | | |
| *Project Name/Number:* | *Accidental Death/GH AR0045807F01* | | |

# Rate Information

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AEGX-126085759* | *State:* | *Arkansas* |
| *Filing Company:* | *Transamerica Life Insurance Company* | *State Tracking Number:* | *41961* |
| *Company Tracking Number:* | *GH AR0045807F01* | | |
| *TOI:* | *H03G Group Health - Accidental Death & Dismemberment* | *Sub-TOI:* | *H03G.000 Health - Accidental Death & Dismemberment* |
| *Product Name:* | *Accidental Death* | | |
| *Project Name/Number:* | *Accidental Death/GH AR0045807F01* | | |

# Supporting Document Schedules

**Satisfied -Name:** Application **Review Status:** Approved-Closed 03/25/2009

**Comments:**

Attached on Forms tab.

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 03/25/2009

**Comments:**

**Attachment:**

AR - READABILITY CERTIFICATION.PDF

**Satisfied -Name:** AR - NAIC TRANSMITTAL DOC **Review Status:** Approved-Closed 03/25/2009

**Comments:**

**Attachment:**

AR - NAIC TRANSMITTAL DOC.PDF

**Satisfied -Name:** AR - NAIC FORM FILING ATTACHMENT **Review Status:** Approved-Closed 03/25/2009

**Comments:**

**Attachment:**

AR - NAIC FORM FILING ATTACHMENT.PDF

**Satisfied -Name:** Explanation of Variability **Review Status:** Approved-Closed 03/25/2009

**Comments:**

**Attachment:**

Explanation of Variability.PDF

**Review Status:**

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AEGX-126085759* | *State:* | *Arkansas* |
| *Filing Company:* | *Transamerica Life Insurance Company* | *State Tracking Number:* | *41961* |
| *Company Tracking Number:* | *GH AR0045807F01* | | |
| *TOI:* | *H03G Group Health - Accidental Death & Dismemberment* | *Sub-TOI:* | *H03G.000 Health - Accidental Death & Dismemberment* |
| *Product Name:* | *Accidental Death* | | |
| *Project Name/Number:* | *Accidental Death/GH AR0045807F01* | | |

**Satisfied -Name:** Cover Letter Approved-Closed 03/25/2009

**Comments:**

**Attachment:**

Cover Letter.PDF

## STATE OF ARKANSAS

## READABILITY CERTIFICATION

**COMPANY NAME:** **Transamerica Life Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

| Form Number | Score |
|---|---|
| GM553 | 43.4 |
| GC553 | 46.9 |
| GGA290 | 40 |
| | |
| | |

Signed: 

Name: Edward G. Weigand

Title: Director

Date: 3-23-09

# Life, Accident & Health, Annuity, Credit Transmittal Document

| 1. | **Prepared for the State of** | Arkansas |
|---|---|---|

| 2. | **Department Use Only** |
|---|---|
| | **State Tracking ID** |
| | |

| 3. | **Insurer Name & Address** | **Domicile** | **Insurer License Type** | **NAIC Group #** | **NAIC #** | **FEIN #** | **State #** |
|---|---|---|---|---|---|---|---|
| Transamerica Life Insurance Company<br>4333 Edgewood Road, N.E.<br>Cedar Rapids IA 52499 | | IA | | 468 | 86231 | 39-0989781 | |

| 4. | **Contact Name & Address** | **Telephone #** | **Fax #** | **E-mail Address** |
|---|---|---|---|---|
| Mary J. DiMarcantonio, ALHC<br>520 Park Avenue<br>Baltimore MD 21201 | | 800-233-4624 | 410-209-5910 | mdimarcantonio@aegonusa.com |

| 5. | **Requested Filing Mode** | ☒ Review & Approval ☐ File & Use ☐ Informational<br>☐ Combination (please explain): _____<br>☐ Other (please explain): _____ |
|---|---|---|

| 6. | **Company Tracking Number** | GH AR0045807F01 |
|---|---|---|
| 7. | ☒ **New Submission** ☐ **Resubmission** | Previous file # _____ |
| 8. | **Market** | ☐ Individual ☐ Franchise<br>Group: ☒ Small ☐ Large ☐ Small and Large<br>☐ Employer ☐ Association ☐ Blanket<br>☒ Discretionary ☐ Trust<br>☐ Other: _____ |
| 9. | **Type of Insurance** | H03G Group Health - Accidental Death & Dismemberment |
| 10. | **Product Coding Matrix Filing Code** | H03G.000 Health - Accidental Death & Dismemberment |
| 11. | **Submitted Documents** | ☒ **FORMS**<br>☒ Policy ☐ Outline of Coverage ☒ Certificate<br>☒ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising<br>☐ Schedule of Benefits ☐ Other: _____<br><br>☐ **RATES**<br>☐ New Rate ☐ Revised Rate<br><br>☐ **FILING OTHER THAN FORM OR RATE:**<br>Please explain: _____<br><br>**SUPPORTING DOCUMENTATION**<br>☐ Articles of Incorporation ☐ Third Party Authorization<br>☐ Association Bylaws ☐ Trust Agreement<br>☐ Statement of Variability ☐ Certifications<br>☐ Actuarial Memorandum<br>☐ Other: _____ |

| | | |
|---|---|---|
| **12.** | **Filing Submission Date** | |
| **13.** | **Filing Fee (If required)** | Amount $50.00 Check Date EFT<br>Retaliatory ☒ Yes ☐ No Check Number |
| **14.** | **Date of Domiciliary Approval** | N/A |
| **15.** | **Filing Description:** | |

Attached for your review and approval are the above referenced forms. These forms are new and do not replace any forms previously approved by your Department. The forms have been completed in "John Doe" fashion.

Group Certificate GC553 is a Group Accidental Death Certificate which provides accidental death benefits for owners of small businesses and their employees. Coverage may include the following benefits and features: Dismemberment Benefit, Persistency Benefit, Full Premium, $1 first period, 30, 60 or 90 day right to examine. The certificates are offered on a guaranteed issue basis. Rates are subject to change after the first certificate year.

GM533 is the master policy under which GC533 certificate will be issued.

The Flesch Readability Score for Master Policy GM553 and GC553 certificate is 43.4 and 46.9, respectively. Microsoft Word 2003 was used to obtain these scores. Variable information is bracketed.

Enrollment Form GGA290 will be used to solicit this coverage.

This coverage may be marketed by direct response and telemarketing methods and possibly on the internet through our website.

We request approval of these forms in various dimensions, format and shading/colors. No dimension/format/shading/color change would produce unacceptable print. These products are guaranteed issue and will be mass marketed by direct response and telemarketing methods and possibly on the Internet through our website.

The referenced forms may be used in other media formats including translations into Spanish, Chinese, Korean, Vietnamese, Polish, etc. and in such case, we certify the content will not change.

**16. Certification (If required)**

**I HEREBY CERTIFY** that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Mary J. DiMarcantonio, ALHC Title Filing Specialist

Signature Mary J. DiMarcantonio Date

| 17. | Form Filing Attachment |
|---|---|
| **This filing transmittal is part of company tracking number** | GH AR0045807F01 |
| **This filing corresponds to rate filing company tracking number** | |

| | Document Name<br>Description | Form Number | | Replaced Form Number<br>Previous State Filing Number |
|---|---|---|---|---|
| 01 | GROUP ACCIDENT INSURANCE POLICY | GM553 | ☒ **Initial**<br>☐ **Revised**<br>☐ **Other** _____ | |
| 02 | Group Accident Insurance Certificate | GC553 | ☒ **Initial**<br>☐ **Revised**<br>☐ **Other** _____ | |
| 03 | Enrollment Form | GGA290 | ☒ **Initial**<br>☐ **Revised**<br>☐ **Other** _____ | |
| 04 | | | ☐ **Initial**<br>☐ **Revised**<br>☐ **Other** _____ | |
| 05 | | | ☐ **Initial**<br>☐ **Revised**<br>☐ **Other** _____ | |
| 06 | | | ☐ **Initial**<br>☐ **Revised**<br>☐ **Other** _____ | |
| 07 | | | ☐ **Initial**<br>☐ **Revised**<br>☐ **Other** _____ | |
| 08 | | | ☐ **Initial**<br>☐ **Revised**<br>☐ **Other** _____ | |
| 09 | | | ☐ **Initial**<br>☐ **Revised**<br>☐ **Other** _____ | |
| 10 | | | ☐ **Initial**<br>☐ **Revised**<br>☐ **Other** _____ | |
| 11 | | | ☐ **Initial**<br>☐ **Revised**<br>☐ **Other** _____ | |

# Explanation of Variables

The following is an explanation of the variables indicated in the submitted forms.

## CERTIFICATE GC553

PAGE 1

COMPANY ADDRESS: Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market. The address on the forms will be one of the following:

a) 2700 West Plano Parkway
Plano, Texas 75075-8200

b) 520 Park Avenue
Baltimore, Maryland 21201

c) Valley Forge, Pennsylvania 19493

Policy number and name are specific to each policy

RIGHT TO EXAMINE: The Right to Examine period will be 30, 60, or 90 days, depending on the marketing strategy.

Personal data will vary in name, benefit, premium, dates, and policy number for each individual customer.

TITLE OF FORM: The title of the form will vary depending on the policyholder's decision to offer dismemberment benefits and type of renewability.

PAGE 2

SCHEDULE PAGE: Personal data on the Schedule of Insurance is variable as it pertains to the Insured, and the amount of coverage purchased.

PAGE 3

DEFINITIONS:

LOSS: the definition will include dismemberment when the policyholder offers the dismemberment benefit.

The definition of Participating Group will be used when the policyholder is a participating group.

WHEN INSURANCE BEGINS: The requirement for the time of submitting the initial premium will vary according to system requirements and payment options.

WHEN INSURANCE ENDS: #4 will vary based on when the policyholder determines the age when coverage ends.

COVERAGE: Dismemberment benefits are described in this section if the policyholder determines that benefit will be offered.

PREMIUMS: The requirement will vary according to system requirements and payment options.

PAGE 4

PERSISTENCY BENEFIT: This benefit will be offered if the policyholder chooses to make it available to the insureds.

REDUCTION: This provision will be included if the policyholder chooses to have benefits reduce and will not exceed 50%.

BENEFICIARY: the percentage may vary if the policyholder chooses but will not exceed 50%

PAGE 5

PAYMENT OF PREMIUM: The Payment of Premium will reflect the same number of days as the Right to Examine period depending on the marketing strategy.

AUTOPSY: this provision will include physical examination if the dismemberment benefit is offered.

PAGE 6

SUPERSEDES PARAGRAPH: This paragraph may or may not be included depending on the marketing strategy

OTHER INSURANCE: If the dismemberment benefit is offered, additional language will be added to include that benefit. The maximum benefit payable may be other than the stated amount.

**GM553**

PAGE 1

COMPANY ADDRESS: Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market. The address on the forms will be one of the following:

d) 2700 West Plano Parkway
Plano, Texas 75075-8200

e) 520 Park Avenue
Baltimore, Maryland 21201

f) Valley Forge, Pennsylvania 19493

Policy number and name are specific to each policy

RIGHT TO EXAMINE: The Right to Examine period will be 30, 60, or 90 days, depending on the marketing strategy.

TITLE OF FORM: The title of the form will vary depending on the policyholder's decision to offer dismemberment benefits and type of renewability.

PAGE 2

DEFINITIONS:

LOSS: the definition will include dismemberment when the policyholder offers the dismemberment benefit

The definition of Participating Group will be used when the policyholder is a participating group.

Eligibility is determined by the program the policyholder chooses.

PAGE 3

WHEN A PERSON BECOMES INSURED: The requirement for the time of submitting the initial premium will vary according to system requirements and payment options.

WHEN A PERSON'S INSURANCE ENDS: #4 will vary based on when the policyholder determines the age when coverage ends.

COVERAGE: Dismemberment benefits are described in this section if the policyholder determines that benefit will be offered.

PAGE 4

PERSISTENCY BENEFIT: This benefit will be offered if the policyholder chooses to make it available to the insureds.

REDUCTION: This provision will be included if the policyholder chooses to have benefits reduce and will not exceed 50%.

PAGE 5

PREMIUM: The Payment of Premium will reflect the same number of days as the Right to Examine period depending on the marketing strategy

BENEFICIARY: the percentage may vary if the policyholder chooses but will not exceed 50

PAGE 6

PAYMENT OF PREMIUM: The Payment of Premium will reflect the same number of days as the Right to Examine period depending on the marketing strategy.

PAGE 7

AUTOPSY: this provision will include physical examination if the dismemberment benefit is offered.

PAGE 8

SUPERSEDES PARAGRAPH: This paragraph may or may not be included depending on the marketing strategy

**ENROLLMENT FORM GGA290**

ADMINISTRATIVE OFFICE variability allows us to administer the product from different locations. Please see the address options listed above.

The title will vary depending on the offer.

"I have read the fraud notice…" reference to Fraud notice will vary based on use of language on the back of the Enrollment Form

Certain codes will appear on the form to enable tracking for marketing purposes.

The marketing plan will determine the no cost period, coverage amounts offered, the percentages for the irrevocable beneficiary and the authorizations used.

The fraud warning notices will be used as required by state

TRANSAMERICA
LIFE INSURANCE COMPANY

Administrative Office | 2700 W. Plano Parkway | Plano | Texas 75075

March 23, 2009

Insurance Commissioner Julie Benafield Bowman
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Form Filing - Small Business Accidental Death with persistency benefit
Health Group
Company Filing#: GH AR0045807F01
Transamerica Life Insurance Company NAIC#: 468-86231 FEIN#: 39-0989781
Lead Form No.: GC553 et al

Dear Commissioner Benafield Bowman:

Attached for your review and approval are the above referenced forms. These forms are new and do not replace any forms previously approved by your Department. The forms have been completed in "John Doe" fashion.

Group Certificate GC553 is a Group Accidental Death Certificate which provides accidental death benefits for owners of small businesses and their employees. Coverage may include the following benefits and features: Dismemberment Benefit, Persistency Benefit, Full Premium, $1 first period, 30, 60 or 90 day right to examine. The certificates are offered on a guaranteed issue basis. Rates are subject to change after the first certificate year.

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TRANSAMERICA
LIFE INSURANCE COMPANY

Administrative Office | 2700 W. Plano Parkway | Plano | Texas 75075



Completed filing forms are attached.

I respectfully request your favorable review. If you have any questions or need any additional information, please call me toll-free at 1-800-233-4624 ext. 5263 or contact me by email at mdimarcantonio@aegonusa.com.

Sincerely,

Mary J. DiMarcantonio, ALHC
Filing Specialist
1-800-233-4624 Ext. 5263
Fax: 410-209-5910
mdimarcantonio@aegonusa.com